From the Overseas Journals

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Manipulating patients

I have never actually visited a chiropracter, except socially, but I can think of circumstances in which I might well do so; the reason would be the absence in the vicinity of an MD with an interest in spinal manipulation. I have recently come across two papers pertinent to the question of manipulation and readers may be interested to hear about them.

Olesen, a Danish general practitioner in Aarhus, a city in Western Denmark, has recorded his results with manipulation of 147 patients during 1973. He has been manipulating spines for 16 years and thinks the results well worth the trouble. In his series he has had no case of aggravation of symptoms. His practice is oriented towards a younger population, including many students, and he has manipulated patients in an age range from 7 to 86 years. In 1973, 32 lesions involved the cervical spine, 61 the thoracic spine and 80 the lumbar spine (the total refers to the number of manipulations, not the number of patients; some patients were given more than one treatment).

Olesen recorded positive results (spontaneous expression of symptom relief) in 137 out of 173 treatments. The main indication for cervical manipulation was headache, especially in young students. Thoracic spine manipulation seems to have been done often for what the author refers to as the "thoracic vertebral facet syndrome", and he believes that the loss of movement at these facets may cause pain in the chest and that this is a common finding in general practice. In his experience manipulation can bring instant relief from pain in this group of patients, who are often "treated" by being reassured that they have no organic disease in the chest. He only manipulated the lumbar spine for relatively mild cases of lumbar pain, mostly in 30- to 50-year-old workers.

The case histories that accompany the article are instructive, with their story of patients having been investigated for such diseases as asthma and angina pectoris and finally being labelled as neurotic because the doctors could find nothing wrong. Manipulation solved the problem.

He believes that any family doctor can easily learn a few manipulations suitable for dealing with most cases, leaving the specialized techniques to the expert. He can in this way save both patient and hospital expenses.

Does the MD necessarily give better care for spinal or back problems than the chiropractor? This is the subject of a study by Kane and colleagues (*Lancet* 1: 1333, 1974), who reviewed all claims made on the Utah State Insurance Fund in 1972 (July to December) for neck and back injuries sustained at work. Workmen's Compensation in that state allows an injured worker to select a therapist from among physicians, osteopaths and chiropractors. A preliminary investigation showed that 147 patients had selected a chiropractor, 336 a physician and 13 an osteopath; 44 played it safe and selected both a physician and a chiropractor. In any case, it is a rather serious finding that at least 30% of persons suffering from neck and back injuries, or both, consulted someone other than a physician.

The authors chose at random a number of patients treated by physicians and an equal number who visited chiropractors, and compared the results in terms of patient satisfaction, functional improvement achieved, attitude to the medical profession and degree of hypochondriasis. Interviews were finally

conducted on 110 MD-treated patients and 122 chiropractor-treated patients in their homes.

The first surprising finding is that there was no difference between the two groups as regards age, race, sex, educational background, income, attitude to the medical profession or degree of hypochondriasis. The average number of visits made to a chiropractor was significantly greater than the number to a physician (12.8 against 7.3), but the MD-treated patients took longer to finish therapy (9.3 weeks against 6.5). In terms of improvement in function, the physicians were actually somewhat less effective, but of course they were presented with significantly greater degrees of disability. Patients visiting chiropractors were more likely to feel that they had been made welcome and were more satisfied with the explanations they received about their problem and its treatment. It would seem from the data presented that physicians scarcely used manipulation at all in treatment and that chiropractors used medication for only 5% of patients.

The authors conclude that, in this study, intervention by a chiropractor was at least as effective as that of a physician, but they point out the limitations to their study: "... we would suggest that there are valuable lessons which the medical profession might learn. These are mainly in the area of medical techniques for communicating with patients."

The results do not necessarily mean that manipulation by chiropractors is better therapy for traumatic lesions of the vertebral column. Such a conclusion would require much more supporting data. It does suggest that physicians are less responsive to the total needs of patients. Maybe it also suggests that there is a bigger place for manipulation of the spine than most of us would allow.

Are routine autopsies useful?

The science and art of clinical diagnosis has advanced greatly since the days when Osler was preaching the virtue of routine autopsies. Recently, it has been questioned whether routine autopsies are of value, especially in clinically clear-cut cases. Two recent reports by Britton, a Stockholm pathologist, suggest that they are. Her study (*Acta Med Scand* 196: 203, 1974) involved 400 consecutive deaths at a university hospital. Physicians classified the cases according to the degree of certainty of the diagnosis: fairly certain, probable and unknown. Errors of diagnosis discovered at autopsy were classified as major, intermediate and minor.

Of the 400 deaths, 383 were asso-

ciated with an autopsy. Of the 383 the clinical diagnosis was confirmed as correct in 220 (57%) and erroneous in 113 (30%). In the remaining 50 cases the diagnosis had been unknown clinically anyway. The errors were classified as 28 major, 25 intermediate and 60 minor ones. In some of these cases the clinical diagnosis was disproved at autopsy; in others it was confirmed but new findings suggested that it was only a contributory cause of death. The two factors that correlated with errors in diagnosis were the age of the patient and the physician's degree of certainty. In patients over 70 years of age there were more errors of diagnosis. In cases in which the physician could only make a probable diagnosis, the degree of error was also great. One peculiar finding is that patients in hospital for less than 72 hours were less likely to have an erroneous diagnosis than those in hospital for longer periods. This is probably because of the high proportion of deaths from acute myocardial infarction, in which the diagnosis is seldom in doubt.

As regards groups of diseases, there was a particularly low rate of error (16%) in cases of neoplasm.

The author lists 15 other studies in the medical literature, and points out that her own percentage of error, 30%, lies among the lowest. However, there is no evidence that the rate of error in diagnosis has diminished over the years, although the diseases and types of mistake have changed. A partial explanation may be that the results of diagnostic improvement are cancelled out by a gradually increased proportion of patients above 70 years old, among whom diagnostic errors are more frequent because the clinical picture is blurred.

In the author's opinion there are good reasons for uncovering these diagnostic errors. The first is the postgraduate education of the doctor. A second is the need for accurate statistics on causes of death. A third is the usefulness of such studies in relation to research on individual disease processes. Finally, the relatives of the deceased may believe it important to know the exact cause of death.

In a companion paper Britton discusses whether experience from autopsy can be used to enrich clinical diagnosis. In the same series of 383 patients the cause of death was assigned on clinical grounds before autopsy and evaluated again by the same clinicians and the author when postmortem findings had been revealed. The diagnoses made before and after autopsy were subsequently compared and the cases analysed from the clinical point of view.

The most common cause of death was myocardial infarction, and this diagnosis was seldom disproved when clinically considered fairly certain. The only misinterpretation was likely to be pulmonary embolism. On the other hand, myocardial infarction had quite often been missed clinically, especially in patients with previous heart disease. In fact, chronic ischemic heart disease was apt to be incorrectly estimated as the most important disorder. Valvular disease and pulmonary disorders were often hidden by a diagnosis of chronic ischemic heart disease. Another major error of diagnosis was that of a cerebrovascular disorder masking a case of brain tumour. As regards neoplasms in general, once a clinical diagnosis was made it was seldom found to be incorrect; unfortunately, neoplasms tended to be underdiagnosed. This is particularly true of cancer of the lung or gallbladder.

Britton also issues a warning about acute surgical disorders occurring in patients in medical wards. The surgical disorder is all too likely to be overlooked. An acute abdomen should always be considered in patients with vague symptoms such as loss of appetite, malaise, fever and general deterioration. Multiple disorders also cause trouble, since clinicians tend to stick to an early diagnosis and overlook the development of new signs and symptoms.

Finally, it is difficult to say how much harm was done by these errors of diagnosis. In many cases they occurred in patients who were aged or at an advanced stage of disease, when such errors were unlikely to affect the outcome.

A posthysterectomy syndrome

If you start asking around among your female acquaintances you may well find that hysterectomy nowadays is a very common operation. You will certainly hear that its after effects last for some time and that when they have subsided the patient is usually very grateful to the operator. So common is hysterectomy that some women talk of a hysterectomy club comparable with the male coronary club.

But hysterectomy is not an operation whose adverse effects disappear quickly. In 1973 Richards reported that women who had undergone hysterectomy were far more likely to become depressed than age-matched controls. In a second paper (*Lancet* 2: 983, 1974) he describes a posthysterectomy syndrome, one feature of which is depression.

He compared a group of 56 women in the Oxford area who had undergone a hysterectomy in 1966-69 with 56 women who had had another type of major operation during the same pe-

riod, such as cholecystectomy, appendectomy, mastectomy, thyroidectomy, gastrectomy, salpingo-oophorectomy or laminectomy. All 112 women were usually attended by one of the family doctors in Richard's group practice. The average age of all subjects was 48 years. All were visited and questioned in 1974.

Depression was found to be much more common in the hysterectomy group (70% of probands *v.* 30% of controls over a 3-year postoperative period). The average duration of treatment was 12.9 months for the hysterectomy group and 4.2 months for controls. Untreated depressions also lasted much longer in those who had hysterectomies. The bias in favour of the group with hysterectomies remained after all patients with a history of preoperative depression were excluded.

A form of postoperative fatigue could be identified by many hysterectomy patients but only by a few controls. Headache, dizziness, stress incontinence and change in libido were also commonly reported after hysterectomy. After this operation women reported that it took an average of almost 1 year before they were restored to normal, as against an average of 3 months in controls.

The author points out that unless hysterectomy patients are told that they may take a long time to recover completely, they will likely become anxious over their slow rate of progress.

How attractive is the practice of medicine?

In 1974 the West German government commissioned a study on the subject "Professional intentions and motivations in German medicine", in which many medical students and doctors from all branches of medicine were questioned. The main object was to obtain information on attitudes towards the practice of family medicine.

The results were gratifying to those who still think well of their profession. Both students and physicians in general thought that medicine was a satisfying profession, even if there was a lot of work and little free time. Few were concerned about the money they would make and most had idealistic attitudes towards helping and healing. But they were conscious of gaps in their education, even in the student years. The students wanted more sociologic, psychosomatic and psychologic content in their course, a familiar cry from many lands. They also wanted more preventive medicine. As regards curative medicine, they repeated the age-old complaint that the patients they saw in hospital were not the sort they would be called upon to treat as family doctors.

Older practitioners lamented the absence of proper teaching on medicolegal subjects, on health insurance problems and on hospital administration. It is not surprising that pediatricians wanted more on social medicine or that gynecologists wanted more on psychosomatics.

Summarizing the results of the study, done by Infratest of Munich, Stobrawa (*Dtsch Aerztebl* 71: 2503, 1974) mentions the alternatives to medicine that the respondents had considered. Practically all had found the alternatives of insufficient interest, and in some cases they would represent a choice dictated by failure to get a place in a medical school. However, the inquiry did disclose the great influence of early associations — contact with academic professions, life in a professional household — on choice of career. Alternatives were mainly in the sphere of biology or the natural sciences, with psychology (12%), law (10%), architecture and the arts (9%) as fairly common choices. For some unknown reason older family doctors seemed to prefer architecture; gynecologists were interested in the law.

In general, the attitude to group practice (in a country where group practices are still rare and were in fact forbidden by law until recently) was favourable for logical reasons (economy, ease of diagnosis, etc.). However, opinion was against group practices in which all the partners offered the same skills. The competitive element and probable unwillingness to cooperate in such practices were cited as reasons for not forming them.

It is encouraging to find that German doctors and medical students have not lost their faith in their profession; the contrast with Britain, where so many seem to have become dissatisfied with their lot, is striking.

Antenatal care in France

A leading French pediatrician, Professor Minkowski, rendered himself extremely unpopular with French family doctors through an incautious utterance on national television last September 12. It seems that the professor, while paying tribute to the services rendered by the 1000 obstetricians and 8000 midwives in France, let it be known that he did not consider that a diploma in medicine gave any family doctor the right to take care of pregnant women, especially in cases at a high risk.

Needless to say, the family doctors of France individually and collectively took exception to these remarks, since it is considered axiomatic in France that anyone with a medical diploma is allowed to perform any type of medical task. The professional body representing family doctors pointed out that if the education of family doctors in antenatal care was defective, it must be the fault of those obstetric services in which they trained as students. The journal *Concours Médical* asked Professor Minkowski to elaborate on his remarks. His attitude was that a few moments of television had produced a greater impact than all his writings in which he had extolled the role of the general practitioner in France. However, he pointed out that the figures for perinatal mortality and for prematurity in France are much worse than those in other civilized countries. He also suggested that in countries where these figures are much lower the surveillance of pregnancy and of the perinatal period is almost entirely in the hands either of obstetricians or midwives.

He agreed that there is a minority of family doctors who are well qualified for antenatal care, but pointed out that in recent years in Paris hospitals only 1 in 10 students had interned in an obstetric department after qualification. Moreover, there is a growing practice for family doctors to give antenatal care but not to deliver the infant. This he believes to be contrary to good sense. He also suggested that many antenatal visits by the family doctor are too hurried to be of good quality.

He believes that, in general, better antenatal care could be given by midwives, although only 11% of pregnant women in France are now in their care. The solution to present problems, in his opinion, lies either in the greater mobilization of midwives for antenatal care or in the establishment of a panel of family doctors who have had special training in obstetrics. ■

Erratum

We regret that in the article of Walfish, Kashyap and Greenstein, "Sulfonylurea-induced factitious hypoglycemia in a nondiabetic nurse", published in the Jan. 11 issue of the Journal (112: 71, 1975), several errors appeared in Tables I and II. The units for plasma insulin should have been μU/ml and the value for plasma insulin at the beginning of the fast was 60 μU/ml. Footnotes were inadvertently omitted from the body of each table. In Table I the single dagger (†) footnote referred to plasma glucose and the double dagger (‡) to plasma insulin. In Table II the † footnote referred to both plasma glucose and plasma insulin, the ‡ footnote to 6 hours and the section mark (§) footnote to 14 hours.